

# APPLICATION FOR TRANSITIONAL COMPENSATION

All information except Item 12 is to be entered by Service representative from Service records.

## SECTION I - PAYEE INFORMATION

(If more than one eligible dependent, use the Remarks section on back to enter applicable information for each payee.)

1. <b>PAYEE NAME</b> (Last, First, Middle Initial)	2. <b>SOCIAL SECURITY NUMBER</b>	3. <b>DATE OF BIRTH</b> (YYYYMMDD)	4. <b>SEX</b> (X one)  <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE									
5. <b>ADDRESS</b>												
a. <b>STREET</b> (Include apartment number)	b. <b>CITY</b>	c. <b>STATE</b>	d. <b>ZIP CODE</b>									
6. <b>RELATIONSHIP TO MEMBER</b> (X one) <input type="checkbox"/> SPOUSE <input type="checkbox"/> FORMER SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> ADOPTED CHILD <input type="checkbox"/> STEPCHILD												
7. <b>CUSTODY</b> (If payee is spouse or former spouse, enter names of dependent children from Item 23 who are in payee's custody) (If all, enter "ALL")	8. <b>INCAPACITATION</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">YES</td> <td style="width: 50%;">NO</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> (X Yes or No for each item)		YES	NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. <b>IS INCAPACITY:</b> (X one) (If applicable) <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY	
	YES	NO										
	<input type="checkbox"/>	<input type="checkbox"/>										
	<input type="checkbox"/>	<input type="checkbox"/>										
<input type="checkbox"/>	<input type="checkbox"/>											
a. <b>IS PAYEE INCAPACITATED?</b> (If Yes, complete Items 8.b. and c., and Item 9.)												
b. <b>IS PAYEE INCAPABLE OF HANDLING FINANCIAL AFFAIRS?</b> (If Yes, complete Item 10.)												
c. <b>IS PAYEE INCAPABLE OF SELF SUPPORT?</b>												

## 10. LEGAL REPRESENTATIVE (Complete only if legal representative is not the payee.)

a. <b>NAME</b> (Last, First, Middle Initial)	b. <b>STREET ADDRESS</b> (Include apartment/suite no.)	c. <b>CITY</b>	d. <b>STATE</b>	e. <b>ZIP CODE</b>
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## 11. IF PAYEE IS A CHILD: (X Yes or No for each item.) (NOTE: Age of majority for a child is 18 in all states except the following: Alabama, Nebraska and Wyoming: age of majority is 19; Mississippi, West Virginia and Puerto Rico: age of majority is 21.)

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	a. <b>WAS INCAPACITY INCURRED BEFORE AGE 18?</b>
<input type="checkbox"/>	<input type="checkbox"/>	b. <b>IF INCAPACITY WAS INCURRED BETWEEN AGES 18 AND 23, WAS THE CHILD A FULL-TIME STUDENT?</b>
<input type="checkbox"/>	<input type="checkbox"/>	c. <b>IS CHILD UNDER THE AGE OF MAJORITY?</b> (See NOTE. If Yes, complete Item 10.)
<input type="checkbox"/>	<input type="checkbox"/>	d. <b>WAS CHILD DEPENDENT ON FORMER MEMBER FOR OVER ONE-HALF OF SUPPORT?</b>

## 12. PAYEE CERTIFICATION (Payee must sign and date to certify that the statements below are correct. Lines (2)-(4) apply only to spouse or former spouse.)

- (1) I am not cohabiting with the former member. If status changes, I will notify DFAS within 30 days.
- (2) I have not remarried. If status changes, I will notify DFAS within 30 days.
- (3) I have custody of the dependent children listed in Item 7.
- (4) I was married to the member in Item 14 at the time of the dependent abuse offense resulting in his conviction/administrative separation.
- (5) I claim payment of transitional compensation under Section 1059, Title 10, U.S.C.
- (6) I understand that I may not receive payments under both Section 1059 and Section 1408(h) of Title 10, U.S.C., and that, if eligible for both, I must elect which to receive. I elect payment of transitional compensation under Section 1059.

a. <b>SIGNATURE</b> (Applicant acknowledges that acceptance of payments if the offender rejoins household is punishable under the law.)	b. <b>DATE SIGNED</b> (YYYYMMDD)
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## SECTION II - MEMBER IDENTIFICATION

13. <b>BRANCH OF SERVICE</b> (X one) <input type="checkbox"/> AIR FORCE <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> ARMY <input type="checkbox"/> NAVY	14. <b>MEMBER NAME</b> (Last, First, Middle Initial)	15. <b>PAY GRADE</b> (Prior to conviction or separation)
16. <b>SOCIAL SECURITY NUMBER</b>	17. <b>DATE OF BIRTH</b> (YYYYMMDD)	18. <b>SEX</b> (X one) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
19. <b>OBLIGATED SERVICE DATES</b> (YYYYMMDD)		
a. <b>ACTIVE DUTY SERVICE ENTRY DATE</b>	b. <b>EXPIRATION OF ACTIVE OBLIGATED SERVICE</b> (Enlisted only)	c. <b>ESTABLISHED DATE OF SEPARATION AT TIME OF CONVICTION/ADMINISTRATIVE SEPARATION</b> (Officer only) (If none, so state)
20. <b>DATE OF APPROVAL OF THE COURT-MARTIAL SENTENCE/ ADMINISTRATIVE SEPARATION</b> (YYYYMMDD) (If court-martial, verify date with approving official. If administrative separation, use date of initiation of separation.)		21. <b>PAYMENT DATES</b> (YYYYMMDD) (Start date is date in Item 20. Length of payment is 36 months except as follows: Subtract date in Item 19.b. or 19.c. from the date in Item 20. If less than 36 months, length of payment is that period or 12 months, whichever is greater.)
		a. <b>START</b> b. <b>STOP</b>

## 22. APPROVING OFFICIAL CERTIFICATION.

I certify that the offense resulting in court-martial conviction or involved in administrative separation is a dependent-abuse offense in accordance with DoD regulations. If married, the spouse was not a participant in the abuse offense.

a. <b>SIGNATURE</b>	b. <b>DATE SIGNED</b> (YYYYMMDD)	c. <b>TITLE</b>	d. <b>TELEPHONE</b> (Include area code)
e. <b>STREET ADDRESS</b> (Include apartment or suite number)	f. <b>CITY</b>	g. <b>STATE</b>	h. <b>ZIP CODE</b>

<b>23. DEPENDENT CHILDREN AT THE TIME OF THE ABUSE</b> <i>(Continue in Remarks if necessary)</i>					
NAME (Last, First, Middle Initial) a.		SOCIAL SECURITY NUMBER b.		DATE OF BIRTH (YYYYMMDD) c.	
SECTION III - REMARKS <i>(Use this area to continue items as necessary. Reference each entry by item number.)</i>					
SECTION IV - APPROPRIATION DATA					
24. DFAS-DE IS AUTHORIZED TO CITE THE FOLLOWING APPROPRIATIONS FOR PAYMENT:					
25. FUND CITE APPROVING OFFICIAL					
a. SIGNATURE		b. DATE SIGNED (YYYYMMDD)	c. TITLE		d. TELEPHONE <i>(Include area code)</i>
e. STREET ADDRESS <i>(Include apartment or suite number)</i>			f. CITY		g. STATE      h. ZIP CODE